STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155775	A. BUILDING 00 B. WING	10/04/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
CUMBERLAND POINTE HEALTH CAMPUS	1051 CUMBERLAND AVE WEST LAFAYETTE, IN 47906

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 0000 Bldg. 00	This visit was for the Investigation of Complaints IN00390828 and IN00379979. Complaint IN00390828 - Substantiated. Federal/state deficiencies related to the allegations are cited at F760. Complaint IN00379979 - Substantiated. No deficiencies related to the allegations are cited. Survey dates: September 30, October 3 and 4, 2022 Facility number: 000547 Provider number: 155775 AIM number: 100267440 Census Bed Type: SNF/NF: 35 SNF: 21 Residential: 43 Total: 99 Census Payor Type: Medicare: 4 Medicaid: 33 Other: 19 Total: 56 This deficiency reflects State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review was completed on October 11, 2022.	F 0000	The submission of this plan of correction does not indicate an admission by Cumberland Pointe Health Campus that the findings and allegations contained herein are accurate, true representation of the quality of care provided, and the living environment provided to the residents of Cumberland Pointe Health Campus. The facility recognizes its obligation to provide legally and medically necessary care and services to its residents in an economic and efficient manner. The facility hereby maintains it is in substantial compliance with all state and federal requirements governing the management of this facility. It is thus submitted as a matter of statute only. The facility respectfully requests from the department a desk review for substantial compliance.	
F 0760 SS=D Bldg. 00	483.45(f)(2) Residents are Free of Significant Med Errors The facility must ensure that its-			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determin other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclo days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155775	A. BUILDING 00 B. WING	10/04/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
CUMBERLAND POINTE HEALTH CAMPUS	1051 CUMBERLAND AVE WEST LAFAYETTE, IN 47906

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	§483.45(f)(2) Residents are free of any significant medication errors. Based on interview and record review, the facility failed to keep a resident free of significant medication errors when the resident was given medications late and not given medication as ordered by the physician for 1 of 3 residents reviewed for medication errors. (Resident B) Finding includes: During an interview, on 9/30/2022 at 4:11 p.m., a family member indicated Resident B was not given his carbidopa-levodopa (a medication for Parkinson's disease) at 8:00 p.m., on 9/16/2022. The medication was to be given every 4 hours. The record for Resident B was reviewed on 10/3/2022 at 1:50 p.m. Diagnoses included, but were not limited to, Parkinson's disease, tremors, hypertension and muscle weakness. The Medication Administration Record (MAR) indicated Resident B was to receive his carbidopa-levodopa 25-250 mg (milligram) medication every 4 hours. The resident received his medication on 9/13/2022 at 9:58 a.m., instead of 8:00 a.m. The MAR indicated Resident B was to receive his carbidopa-levodopa 25-250 mg medication every 4 hours. The resident received his medication on 9/13/2022 at 1:30 p.m., instead of 12:00 p.m. The MAR indicated Resident B was to receive his carbidopa-levodopa 25-250 mg medication every 4 hours. The resident did not receive his medication on 9/13/2022 at 4:00 a.m. The MAR indicated Resident B was to receive his	F 0760	1. There was 1 resident affected. Resident B had discharged from facility prior to survey entrance. 2. Any resident receiving medications has potential to be affected. The DHS or designee will audit all MARs to review for omitted or late medication administrations and notify the provider as indicated. 3. The DHS or designee will provide education to nurses and QMAs on medication administration related to medication error and time management. 4. DHS or designee will audit medication administrations records of 10 residents for any omitted or late medication administrations weekly for 4 weeks, then 10 residents every other week for 4 weeks, then 10 residents monthly for 4 months or until 100% compliance is achieved. Findings will be reviewed in QA. 5. Substantial compliance will be achieved by 10/18/2022	10/18/2022

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155775	A. BUILDING 00 B. WING	10/04/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
CUMBERLAND POINTE HEALTH CAMPUS	1051 CUMBERLAND AVE WEST LAFAYETTE, IN 47906

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	carbidopa-levodopa 50-200 mg medication every 4 hours. The resident received his medication on 9/13/2022 at 9:58 a.m., instead of 8:00 a.m. The MAR indicated Resident B was to receive his carbidopa-levodopa 50-200 mg medication every 4 hours. The resident received his medication on 9/13/2022 at 1:30 p.m., instead of 12:00 p.m. The MAR indicated Resident B was to receive his carbidopa-levodopa 25-250 mg medication every 4 hours. The resident did not receive his medication on 9/14/2022 at 12:00 a.m. During an interview, on 10/3/2022 at 2:30 p.m., with the Minimum Data Set (MDS) nurse 2 and the Regional Clinical Support (RCS) 3 regarding Resident B's medication administration, MDS nurse 2 indicated Resident B received his medication carbidopa-levodopa 25-250 mg on 9/13/2022 late at 9:58 a.m., instead of 8:00 a.m., per physician orders. The RCS 3 indicated Resident B received his medication carbidopa-levodopa 25-250 mg on 9/13/2022 late at 1:30 p.m., instead of 12:00 p.m., per physician order. The MDS nurse 2 indicated Resident B did not receive his carbidopa-levodopa 25-250 mg medication on 9/14/2022 at 12:00 a.m., per physician order. The RCS 3 indicated Resident B did not receive his carbidopa-levodopa 25-250 mg medication on 9/14/2022 at 4:00 a.m., per physicians order. During an interview, on 10/3/2022 at 2:40 p.m., with the MDS nurse 2 and the RCS 3 regarding Resident B's medication administration, the MDS nurse 2 indicated Resident B received his medication carbidopa-levodopa 50-200 mg on 9/13/2022 late at 9:58 a.m., instead of 8:00 a.m. On 9/13/2022, Resident B received his medication carbidopa-levodopa 25-250 mg at 1:30 p.m.,			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155775	A. BUILDING 00 B. WING	10/04/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
CUMBERLAND POINTE HEALTH CAMPUS	1051 CUMBERLAND AVE WEST LAFAYETTE, IN 47906

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	instead of 12:00 p.m., per physicians order. The RCS 3 indicated Resident B did receive his carbidopa-levodopa medication for 9/16/2022 at 8:00 p.m., on the evening his family thought he did not recieve it. This Federal tag relates to Complaint IN00390828. 3.1-48(c)(2)			